HUMANA®

500 West Main Street
Louisville, KY 40202

This is a brief plan description. It is not the plan document and does not include all of the benefits, limitations and exclusions of the Plan. More complete terms of the Plan are contained in the Certificate of Coverage.

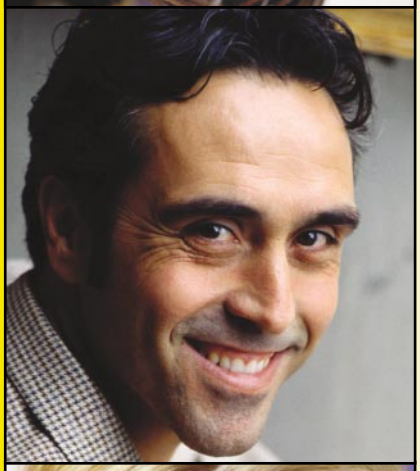
HUMANA®

www.humana.com

Offered by Humana Health Plan, Inc.

GHC IN-0282

10/02



benefit summary

for

State of Indiana Employees

HMO Plan

Open Enrollment

HUMANA®

www.humana.com

Humana is proud to offer affordable rates and a wide range of health care benefits to State of Indiana employees. Let Humana care for you and your family in 2003.

Advantages of the HMO Maximum Benefit Plan

- No charge for hospitalization
- No charge for surgeon and inpatient physician fees
- No deductibles
- No claim forms to file
- Discount dental service included

The following counties are in the HMO Maximum Benefit Plan service area:

- **Northern Indiana counties**
  Lake, LaPorte and Porter
- **Southern Indiana counties**
  Clark, Crawford, Floyd, Harrison, Jackson, Jefferson, Jennings, Orange, Scott and Washington.
  Also, in the Louisville area, Bullitt, Hardin, Henry, Jefferson, Marion, Meade, Nelson, Oldham, Shelby, Spencer and Washington.

(Employees must live or work in the service area in order to be eligible to enroll.)

During open enrollment or if you're a newly hired employee looking for additional information or to order benefit packets, call:

Toll free

1-888-393-6765

8 AM to 8 PM Eastern Time Monday - Friday

For Customer Service throughout the remainder of the year, please call:

1-800-494-7156

At Humana, we know that choosing a health care plan may not be the most exciting thing you'll do, but it is one of the most important decisions you will make. So we want to give you all the information you'll need to make the best possible choice.

HMO Maximum Benefit Plan Custom Plan M01

Annual Deductible	None
Maximum out-of-pocket for covered expenses	$1,000 single $2,000 family

Services	Covered benefits	Cost to member
Hospital (Refer to provider directory for a list of participating hospitals.)	Inpatient care • Room and board • Ancillary services • General nursing care • Physician visits	**NO CHARGE**
	Outpatient care • Preadmission testing • Outpatient surgery and other outpatient services	**NO CHARGE**
Physician (Visits to specialists must be authorized by your primary care physician.)	Office visits Health screening exams (maximum 1 per calendar year) Pediatric care (under age of 18) Diagnostic lab tests and X-rays Immunizations Pap smears Surgery, including anesthesia Hearing screenings under the age of 18 at primary care physician's office	$5 copayment per visit ($10 copayment per visit for specialists)
	Allergy treatments and materials	**NO CHARGE**

Services	Covered benefits	Cost to member
Emergency services	Emergency care services (when not admitted)	$10 copayment per visit (waived if admitted)
	Emergency room visit by physician	**NO CHARGE**
	Ground ambulance service	**NO CHARGE**
Other medical services (In physician's office, participating hospital, other authorized facilities or home, if medically necessary)	Home health care	**NO CHARGE**
	Skilled nursing facility - 100 day limit per calendar year	**NO CHARGE**
	Durable medical equipment	**NO CHARGE**
	Radiation therapy or X-ray treatments	**NO CHARGE**
	Laboratory procedures	**NO CHARGE**
	Short-term speech, physical and respiratory therapy (limited to 60 consecutive days per sickness or injury; no limit if member's condition can improve significantly within two months)	**NO CHARGE**
	Hospice (includes bereavement counseling)	Outpatient: **NO CHARGE**; plan provides up to $2,000 in coverage per calendar year. Inpatient: **NO CHARGE**; plan provides up to $3,000 in coverage per calendar year.
Additional coverage	Maternity services	Same as any other covered condition
	Family planning • Infertility counseling and testing • Tubal ligation • Vasectomy	20 percent copayment
	Prescription drugs	See next page for more details.
Alcohol and chemical dependency*	Detoxification (inpatient or outpatient whichever is medically necessary)	**NO CHARGE** for covered services
	Inpatient rehabilitation (limited to 10 days per calendar year)	Plan provides the first $50 of covered expenses per day
	Outpatient rehabilitation (limited to 20 visits per calendar year)	$20 copayment per visit
Mental and nervous disorders*	Inpatient services Outpatient services	Same as any other covered condition

*Covered only when provided or authorized in advance by Humana Inc.; referrals to a participating Humana Inc.'s psychiatrist's office, a participating hospital or other approved health care facility or program shall in all cases be at the sole discretion of Humana Inc.

Dental, breast cancer services and major transplant benefit information follows.

Your participating primary care physician must authorize or direct all health services received under the plan. You must choose a primary care physician from the participating provider directory.

This is a brief plan description of the plan. More complete information, including exclusions and services not covered, is contained in the Group Plan/Certificate of Coverage. Information regarding the financial condition of Humana Inc. may be obtained by contacting its offices.

Rx3 Prescription Drug Coverage $5 generic/$10 brand/ $15 not listed on drug list

Participating pharmacy coverage

When you present your membership card at a participating pharmacy, you will be required to make a copayment for your prescriptions based on the type of medication you purchase:

- For a generic drug on the Humana Drug List, you will make a $5 copayment for a maximum 30-day supply.
- For a brand-name drug on the Humana Drug List, when a generic equivalent is not available, you will make a $10 copayment for a maximum 30-day supply. If a generic is available, you must make the generic copayment **and** be responsible for the difference between the amount paid by Humana to the dispensing pharmacy for the brand-name drug and the amount Humana would have paid the dispensing pharmacy for its generic equivalent.*
- For a drug that is not on the Humana Drug List, you will make a $15 copayment for a maximum 30-day supply. If a brand-name drug, not on the Drug List is dispensed when a generic is available, you will make the $15 copayment **and** be responsible for the difference between the amount paid by Humana to the dispensing pharmacy for the brand-name drug and the amount Humana would have paid the dispensing pharmacy for its generic equivalent.*
- Your copayments for covered prescription drugs are made on a per prescription or refill basis and will not change if Humana receives any retrospective volume discounts or prescription drug rebates.

There are no claim forms to file if you present your membership card with each prescription.

*If your physician requires the dispensing of a brand-name drug, you will make the applicable copayment and will not be responsible for any difference between the amount paid by Humana to the dispensing pharmacy for the brand-name drug and the amount Humana would have paid the dispensing pharmacy for its generic equivalent.

Coverage specifics

Your coverage includes the following:

- A 30-day supply or the amount prescribed, whichever is less, for each prescription or refill.
- Oral contraceptives.
- Certain self-administered injectable drugs approved by Humana will be paid at the applicable copayment.
- Certain drugs, medicines or medications that under federal or state law may be dispensed only by prescription from a physician.

Some drugs may be subject to prior authorization requirements for coverage under the plan. Additionally, some drugs may have dispensing limitations, which limit coverage based on duration, age, gender or dosage criteria. To determine whether a drug prescribed for you may be affected by these coverage limitations, please contact customer service or visit our Web site.

For a complete listing of participating pharmacies, please refer to your participating provider directory.

Humana Drug List

The Humana Drug List (may be referred to in your certificate as "formulary") is a list of prescription drug products. Prescription drug products, or classes of certain prescription drug products, are generally reviewed by a medical committee comprised of physicians and pharmacists for safety, effectiveness and cost-effectiveness prior to placement on the Humana Drug List. The committee regularly updates the Drug List and reviews existing prescription drug products on a case-by-case basis. You should always discuss prescription drugs with your physician to determine appropriateness or clinical effectiveness with respect to you or any specific illness. This list is subject to change during the plan year. Information about the Humana Drug List is available to members by contacting a customer service representative at the phone number listed on your plan ID card, or visit our Web site at **www.humana.com**.

Mail-order benefit

For your convenience, you may receive a maximum 90-day supply of a prescribed maintenance medications through the mail. Copayments are based on the specific group plan. Please see your benefits administrator for specific pharmacy mail-order copayment requirements for your group.

The same requirements apply to selection of brand-name drugs when generic equivalents are available, as apply when purchasing in person at a participating pharmacy.

Please refer to the mail-order brochure for a more detailed description of mail-order benefits. If you do not have this brochure, it can be obtained by contacting Customer Service or your benefits administrator.

Definition of terms

- Brand-name medication (drug): a medication that is manufactured and distributed by only one pharmaceutical manufacturer or as defined by the national pricing standard used by Humana.
- Copayment: the amount to be paid by the insured person toward the cost of each separate prescription or refill of a covered drug when dispensed by a pharmacy.
- Generic medication (drug): a medication that is manufactured, distributed and available from several pharmaceutical manufacturers and identified by the chemical name or as defined by the national pricing standard used by Humana.
- Maintenance medication (mail order drugs): any prescription drugs that 1) are generally prescribed for treatment of long-term chronic sicknesses or injuries and 2) are purchased from the pharmacy contracted with Humana to dispense mail order drugs.
- Nonparticipating pharmacy: a pharmacy which has not been designated by Humana as a participating pharmacy.
- Participating pharmacy: a pharmacy which has entered into an agreement with Humana or which has been designated by Humana to provide services to all covered persons. Participating pharmacy designation by Humana may be limited to specified services.

Limitations and exclusions

Unless specifically stated otherwise, no coverage is provided for the following:

- Any portion of a prescription or refill that exceeds a 30-day supply for a nonmaintenance medication (90-day supply for a maintenance medication)
- Prescription refills in excess of the number specified by the physician's original order or dispensed more than one year from the date of the original order
- The administration of a covered medication
- Immunizing agents, biological sera or allergen extracts
- Any drug or medicine that is lawfully obtainable without a prescription
- Fertility medications (may be covered under the medical plan)
- Prescriptions filled at a nonparticipating pharmacy, except for prescriptions required during an emergency
- Drug delivery implants
- Any drug, medicine or medication labeled "Caution - limited by federal law to investigational use" or any experimental drug, medicine or medication, even though a charge is, or may be, made to the member
- Dietary supplements (except for formulas or low protein modified foods necessary for the treatment of phenylketonuria or certain other inheritable diseases of amino and organic acids)
- Any costs related to the mailing, sending or delivery of prescription drugs
- Contraceptives, other than oral, whether medication or device, regardless of the purpose for which they are prescribed
- Anoretic or any drug used for the purpose of weight control
- Any drug prescribed for a noncovered sickness or injury

This is only a partial list of limitations and exclusions. Please refer to your Certificate for complete details regarding prescription drug coverage.

Dental services DEN-802

- You present your membership card to a participating general dentist.
- You receive preventive dental care at a discounted fee.
- You may also receive a 20 percent discount on other services (see details below).

To receive the coverage provided by your plan, all dental care must be provided by participating dentists and in conjunction with a paid procedure, such as cleanings, fillings, extractions, root canals, crowns or dentures.

The following preventive dental services are provided at no charge, **when performed in conjunction with other paid services:**

- Oral examination (limited to one every six months)
- Necessary bitewing X-rays (maximum of eight as necessary within benefit year)
- Fluoride treatment for children under age 16 only (limited to one every six months)

A 20 percent discount is applied for the above services when provided beyond the listed limits. This discount also applies to the entire cost of all other general dental services, excluding orthodontics.

This discount program is not intended to replace any dental benefits you may have. As always, please remember to bring a dental insurance form with you when you visit your participating Humana dentist.

Limitations

- Oral examinations are limited to once every six (6) months.
- The participating general dentist has the right to refuse treatment to a member who fails to follow a prescribed course of treatment.
- Copayments apply only when treatment is performed at a participating general dentist office. If a member obtains dental services from someone other than a participating general dentist, the member is responsible for all costs.
- If a member transfers from the care of one participating general dentist to another participating general dentist during the course of treatment, the plan covers only the original procedure performed by the original participating general dentist.

Exclusions

- Orthodontia;
- Services not provided in a participating general dentist's office;
- Any dental service not listed contained on the DEN 802 schedule;
- Fluoride treatment for members 16 years of age and older; and
- Members covered under any other dental service rider.

For Southern Indiana: Please see provider directory for participating dentists.

For Northern Indiana: New providers are constantly being added to our network, please call your dentist to confirm that he/she is a member of our dental network.

In Northern Indiana: Humana Health Plan, Inc. dental plan is offered by Humana Health Plan, Inc. and administered by TDC/The Dental Concern, LTD.

Breast cancer services

Description of services	Special provisions	You pay
Diagnostic services for a procedure intended to aid in the diagnosis of breast cancer including the following:		
Breast cancer screening mammography, including interpretation	• A baseline mammogram for women ages 35-39. • For "women at risk" one mammogram per year between the ages 40 and 50. • For women not at risk, one mammogram every two years between ages 40 and 50. • For all women ages 50 and above, one mammogram per year.	**NO CHARGE**
Surgical breast biopsy		**NO CHARGE**
Pathologic examination and interpretation		**NO CHARGE**
Outpatient treatment services for procedures that are intended to treat breast cancer and include the following:		
Chemotherapy		**NO CHARGE**
Hormonal therapy		**NO CHARGE**
Radiation therapy		**NO CHARGE**
Surgery		**NO CHARGE**
Other treatment services prescribed by a physician		**NO CHARGE**
Medical follow-up services related to services above		**NO CHARGE**
Rehabilitative services for procedures that are intended to improve the results of or to ameliorate the debilitating consequences of the treatment of breast cancer and includes the following:		
Physical therapy		**NO CHARGE**
Psychological and social support services		**NO CHARGE**
Reconstructive plastic surgery		**NO CHARGE**

The term **breast cancer screening mammography** means a standard, two (2) view per breast, low-dose radiographic examination of the breasts furnished to a covered member by a provider.

The term "women at risk" include:

1. One with a personal history of breast cancer;
2. One with a personal history of breast disease which was benign upon biopsy;
3. One whose mother, sister or daughter had breast cancer; and
4. One who is 30 or over and has never given birth.

Organ transplant services

We will cover services for covered organ transplant expenses, as defined below, incurred by a member for an organ transplant approved by us at a facility approved by us, subject to those conditions and limitations described below.

TRANSPLANT means pretransplant, transplant inclusive of any chemotherapy and associated services and post-discharge services and treatment of complications after transplantation. We will cover only services, care and treatment received for or in connection with the approved transplantation of the following human organs:

- Heart;
- Lung(s);
- Heart-lung(s);
- Liver, for the following diagnoses: Biliary Atresia, Primary Biliary Cirrhosis, Primary Sclerosing Cholangitis, Postnecrotic Cirrhosis Hepatitis B Surface Antigen Negative, Alcoholic Cirrhosis (only if 6 months abstinence from alcohol is documented), Alpha-1 Antitrypsin Deficiency Disease, Wilson's Disease, Primary Hemochromatosis. Diagnoses not covered for liver transplantation include, but are not limited to, the following diagnoses: Primary or Metastatic Cancer of the Liver, Hepatitis B Surface Antigen Positive, Secondary Biliary Cirrhosis, Lupus Hepatitis or Autoimmune Hepatitis, Cytomegalovirus Hepatitis, Epstein-Barr Virus Hepatitis, Budd-Chiari Syndrome, Veno-Occlusive Disease, Liver damage caused by chemicals, toxins or external agents, Alcoholic Cirrhosis without 6 months abstinence from Alcohol;
- Kidney;
- Bone marrow (allogenic, autologous and peripheral blood stem cells) for Wiskott-Aldrich Syndrome Severe Combined Immuno-Deficiency Syndrome, Leukemia, Lymphoma, Aplastic Anemia, Ewing's Sarcoma, Neuroblastomas. We will not cover bone marrow transplants (allogenic, autologous or peripheral blood stem cells) for treatment of cancers or diseases of the brain, bone, large bowel, ovary, small bowel, testicle, esophagus, kidney, liver, lungs, pharynx, prostate, skin, connective tissue and uterus. We will not cover bone marrow transplants for any congenital, genetic or metabolic disorders affecting or originating in the blood-forming (hematopoietic) system except as stated above as covered.
- Simultaneous Pancreas/Kidney

Corneal transplants, which are tissues rather than organs, are considered part of regular plan benefits and are covered upon approval of the primary care physician.

As used in this document, the term "bone marrow transplant" means human blood precursor cells which are administered to a patient following ablative or myelosuppressive therapy. Such cells may be derived from bone marrow, circulating blood or a combination of bone marrow and circulating blood obtained from the patient in an autologous transplant or from a matched related or unrelated donor. If chemotherapy is an integral part of the treatment involving bone marrow transplantation, the term "bone marrow transplant" includes the harvesting, the transplantation and the chemotherapy components.

For a transplant procedure to be considered approved, prior approval from the company's Medical Affairs Department is required in advance of the procedure. You or your primary care physician must notify us in advance of your initial evaluation for the procedure in order for us to determine if the transplant services will be covered. For approval of the transplant itself, the company's Medical Affairs Department must be given the opportunity to evaluate the clinical results of the evaluation. Such evaluation and approval will be based on written criteria and procedures established by the company's Medical Affairs Department. If approval is not given, benefits will not be provided for the transplant procedure.

Covered expenses

For approved major transplant procedures and all related complications, we will cover only the following expenses:

- Hospital expenses and physician's expenses, under the same terms and conditions as we will cover care and treatment of any other covered injury or sickness.
- Organ acquisition and donor costs. However, donor costs are not payable under the Group Plan if they are payable in whole or in part by any other group plan, insurance company, organization or person other than the donor's family or estate.

Exclusions

No coverage is available for or in connection with a transplant if:

- The organ or diagnosis involved is not listed in this subsection of the Group Plan. Transplants that are not covered include, but are not limited to: islet cells, bowel, pancreas, stomach, thymus and pituitary. Bone marrow and liver transplants are also excluded except as stated as covered in the subsection of the Group Plan.
- The company's Medical Affairs Department is not contacted for authorization prior to referral for transplant evaluation of the procedure.
- The company's Medial Affairs Department does not approve coverage for the procedure, based on its established criteria.

- The transplant procedure is performed in a facility that has not been designated by the company's Medical Affairs Department as an approved transplant facility.
- Expenses are entitled to be paid under any private or public research fund, government program except Medicaid, or other funding program.
- The expense relates to the transplantation of any non-human organ or tissue.
- The expense relates to the donation or acquisition of an organ for a recipient who is not covered by us.
- A denied transplant is performed; this includes the transplant procedure, follow-up care, immuno-suppressive drugs and complications of such transplant.

The following services/supplies/expenses are also not covered:

- Artificial heart devices (excluding VAD - ventricular assist device unless specifically stated in contract) used as a bridge to transplant.
- Drugs used in connection with diagnosis or treatment leading to a transplant when such drugs have not received FDA approval for such use.

Once the transplant procedure is approved, the company's Medical Affairs Department will advise the member's physician of those facilities that have been approved for the type of transplant procedure involved. Coverage is available only if the pretransplant services, the transplant procedure and post-discharge services are performed in an approved facility.

Limitations and Exclusions

This is a partial list of limitations and exclusions. Your group may have specific limitations and exclusions not included on this list. Please check your Group Contract/Certificate of Coverage for this complete listing. The Group Contract/ Certificate of Coverage is the document upon which benefit payment will be determined.

Unless specifically stated otherwise, no services will be provided or paid for or on account of:

- care for conditions that state or local law requires to be treated in a public facility.
- any charge which would not have been made if the member had no coverage or any charge the member would not be legally required to pay.
- education or training; medical services provided by the member's parent, spouse, brother, sister or child.
- experimental drugs or substances not approved by the Food and Drug Administration; drugs or substances used for other than Food and Drug Administration approved indications; or drugs labeled: "Caution – limited by Federal Law to investigational use."
- vitamins, birth control pills and non prescription drugs or medicines unless added by a rider to the Group Plan.
- treatment, services, supplies or surgery that is not medically necessary.
- the purchase or fitting of hearing aids or advice on their care.
- weekend nonemergency hospital admissions.
- in-vitro fertilization; sex change services; or reversal of elective sterilization.
- experimental procedures or treatment methods, as defined by the medical community.
- cosmetic and reconstructive surgery, except reconstructive surgery which is:
  - incidental to or following surgical removal of all or less than all of a body part. The surgical removal must be the result of injury or sickness of the body part.
  - done because of a sickness or a disorder of a normal bodily function.
  - done to repair or lessen damage caused by an accident taking place on or after the effective date of this coverage for the member.
- services and supplies for dental services, treatment of the teeth or periodontium, oral surgery or any other orthodontic treatment regardless of medical necessity, unless (a) the services and supplies are for the treatment of temporomandibular joint (TMJ) syndrome/ dysfunction or craniomandibular jaw disorder (CMJ); or (b) the services are received in connection with an injury to sound natural teeth or jaw sustained while the person is covered by the Group Plan. We will cover: (a) hospital room and board and medically necessary services and supplies provided while hospital confined; and (b) a physician's services in performing a surgical procedure. For an injury, the care and treatment must be provided within the 12 month period beginning on the date of the injury. Also, the member must remain covered under the Group Plan during the 12 month period while the care and treatment is being received.
- services and supplies for treatment of temporomandibular joint (TMJ) syndrome/ dysfunction and craniomandibular jaw disorders (CMJ) which are recognized as dental procedures. This includes, but is not limited to, the extraction of teeth and the application of orthodontic devices and splints.
- any services, supply, care or treatment provided to the member without the authorization of his or her primary care physician, unless the member is receiving emergency health services.
- care and treatment of the feet, unless such services are medically necessary as determined by the member's primary care physician.

- orthotic devices, unless such orthotic devices are custom fitted to the member. We do not provide coverage for the repair of orthotic devices.
- for any service, supply or treatment connected with custodial care. We do not provide these services no matter who provides, prescribes, recommends or performs them. Custodial care means services designed to help a member meet the needs of daily living, whether or not he or she is disabled. These services include help in:
  - walking or getting in or out of bed;
  - personal care such as bathing, dressing, eating or preparing special diets; or taking medication which the member would normally be able to take without help.
- enrollment in a health, athletic, or similar club; or a weight loss or similar program
- purchase or rental of supplies of common household use such as: exercise cycles; air purifiers; central or unit air conditioners; water purifiers; allergenic pillows or mattresses or waterbeds.
- purchase or rental of: motorized transportation equipment; escalators or elevators; saunas or swimming pools; professional medical equipment such as blood pressure kits; or supplies or attachments for any of these items.
- convenience or personal care services such as use of a telephone or television.
- any surgical procedure to reduce obesity, unless medically necessary.
- elective abortion, unless the primary care physician and the Group Plan agree and certify in writing that the pregnancy would endanger the life and health of the mother.
- all human organ and tissue transplants, except heart, liver, kidney, cornea and bone marrow transplants. Details are explained in our major transplant benefit rider.
- vision training or the purchase of eyeglasses or contact lenses.
- acupuncture, unless:
  - the treatment is medically necessary and appropriate and is provided within the scope of the accupuncturist's license;
  - the insured person is performed in lieu of generally accepted anesthesia practices.
- routine physical examinations when required for employment, school or for an insurance company.
- spinal manipulations and subluxations, unless medically necessary.
- any services, supply, care or treatment that is not described in the Group Plan or any rider attached to it.
- eye refractions, unless listed as covered in your Health Services Agreement.
- services provided prior to the effective date or after the termination date of your coverage under the Group Plan. Coverage will be extended under the Extension of Coverage under the Health Services Agreement when the Group Plan Terminates provision, if such coverage is required by state law.

Humana Privacy Notice

Relationships are built on trust. One of the most important elements of trust is respect for an individual's privacy. We at Humana value our relationship with you, and we take your personal privacy seriously.

This privacy notice explains how we manage the personal and health information we have obtained from you and how that information has been, or may be, collected. It also explains that your personal and health information is used in administering your plan, and may be available to affiliated companies in order to provide you with offers for products and services you may find of value. Please read this notice carefully.

You have received this notice because you are covered by, considering coverage with, or have applied for coverage with, a product offered, insured or administered by an insurance company or managed care organization operating as a subsidiary of Humana Inc. ("Humana"). A current list of such companies and organizations appears at the end of this notice.

You may instruct Humana to withhold your personal information from affiliated companies. For details, please refer to the section entitled "Your 'Opt Out' Choice."

You, like all Humana members, are at the center of all we do. We appreciate your membership, and we remain focused on continuing to earn the trust and confidence you have placed in Humana.

Information we collect about you

We collect nonpublic personal information ("Personal Information") about you or your family when you complete your enrollment application and from your transactions with us, our affiliates, or others. We may contact you directly to obtain additional information or to answer any questions we have about your enrollment application. We may also receive Personal Information about you from other sources, including participants in the health care system, such as your doctor or hospital, as well as from your employer or plan administrator, credit bureaus, and the Medical Information Bureau.

This Personal Information we receive may include your name, address, telephone number, date of birth, Social Security Number, your employer, premium payment history, if applicable, and information from your activity on our Web site.

We may also receive from these sources information about your physical or mental health condition, health care provided to you, or your payments for health care ("Health Information"). The Health Information we receive may include health care providers you have seen, medical services rendered to you, charges for those services, and your medical diagnosis.

Our records may also contain Personal and Health Information regarding your insurance or medical benefit plan, such as type of insurance coverage or medical benefit plan, benefits, claims history, service authorizations when needed, information regarding coverage inquiries you have made, and health risk assessments.

How your information is used

The Personal and Health Information Humana obtains and stores about you and your family is used to effectively administer your plan. We may share your Personal and Health Information with affiliated companies and nonaffiliated third parties, as permitted by law, as part of our administration of your plan.

For example, Humana may provide your Personal and Health Information to the following types of third parties: physicians and other medical providers or facilities; medical review agencies; state or federal governmental or insurance regulating bodies; other insurance companies to coordinate benefits; disease management coordinators; your or your employer's agent, broker, or benefits administrator; and other firms involved in assisting us in administering your plan. We may also provide your Personal Information to other financial institutions with which we have joint marketing agreements in order to provide you with offers for products and services you may find of value. Your Personal Information will not be provided in this manner if we are administering (rather than insuring) a medical benefit plan on behalf of a self-funded employer and your employer has requested that Humana not share such information.

Affiliates to whom we may disclose your personal and health information

Our affiliates are a family of companies that provide health care coverage or insurance services or administer health benefits for self-funded plans. We may disclose Personal and Health Information to affiliates who provide health, dental and life insurance-related services.

Safeguarding your personal and health information

We restrict access to your Personal and Health Information to those employees who need to know that information to provide services to you. We maintain physical, electronic, and procedural safeguards that comply with federal regulations to guard your Personal and Health Information.

Changes to our privacy policy

We will supply you with a copy of our privacy policy annually. Humana occasionally reviews its privacy policy and reserves the right to amend it. If we make material changes to this policy, we will provide our current members with a revised Privacy Notice that describes our new policy before it becomes effective.

Disclosures to provide you with offers of services

We may disclose your Personal Information to affiliated companies in order to provide you with offers for products and services you may find of value and which are not products offered by Humana. Your Personal Information will not be provided in this manner if we are administering (rather than insuring) a medical benefit plan on behalf of a self-funded employer and this employer has requested that Humana not share such information. Regardless of whether your employer has made such a request, you may elect to opt out of these disclosures. You may opt out of these disclosures and from receiving products and services that result from these disclosures by following the opt out procedures described below.

Your 'opt out' choice

At any time you may instruct Humana not to share any of your Personal Information with affiliated companies that will provide you offers of non-Humana products or services described in the above section entitled "Disclosures to Provide You with Offers of Services."

An opt out request will apply to all members or insureds covered under a single identification number or account number and will continue to apply until you revoke your request.

If you wish to exercise your choice to opt out of these disclosures, or to revoke a previous opt out request, you may use one of the following methods to notify us:

- You may telephone us at 1-866-861-2762. You will be asked to provide information including your name, date of birth and member number. This information is necessary to process your request.
- You may send us your request in writing. You must include your date of birth and your Humana Member Identification number, which you will find on your Humana Member ID card. You may mail your written opt out request to us at Humana Privacy Office, P.O. Box 1438, Louisville, KY 40202.
- You may e-mail your request to us at privacyoffice@humana.com. Be sure to include your name, date of birth and member identification number.

Once your request has been processed, it will remain in effect until you request a change.

HUMANA INC. SUBSIDIARIES WITH HMO AND INSURANCE LICENSES

Emphesys Insurance Company
Humana Employers Health Plan of Georgia, Inc.
Humana Group Health Plan, Inc.
Humana Health Insurance Company of Florida, Inc.
Humana Health Plan of Ohio, Inc.
Humana Health Plan of Texas, Inc.
Humana Health Plan, Inc.
Humana Health Plans of Puerto Rico, Inc.
Humana Insurance Company
Humana Insurance Company of Kentucky
Humana Insurance of Puerto Rico, Inc.
Humana MarketPOINT, Inc.
Humana Medical Plan, Inc.
Humana Wisconsin Health Organization Insurance Corporation
HumanaDental Insurance Company
The Dental Concern, Inc.
The Dental Concern, Ltd.